Office Co-pay Reimbursement Policy

Effective January 1, 2006

Grant County will reimburse employees for eligible $10 office co-pays for themselves and dependents covered under Grant County Health Insurance above and beyond twelve per plan that occur between January 1 and December 31 of each year. The first twelve office co-pays are the responsibility of the employee.

The following information is required to be received in the Personnel Office before reimbursement is made.

- Reimbursement request form
- Proof of office co-pays paid by employee's with service dates, including the first twelve. The proof of payment can be in the form of a receipt or an official statement from the physician's office.

The Personnel Office will accept reimbursement requests on the following dates and reimbursement will be made within fifteen days or as soon as reasonably possible.

April 10
July 10
October 10
January 15 (for the prior years office co pays) Requests received after this date for the prior years co-pays will be forfeited.

Please note: The IRS regulations for section 125 reimbursement (EBC FLEX) does not allow an individual to deduct pre-tax any reimbursement that will be made by both the employer and EBC FLEX. The most you can deduct from your check for EBC Flex will be for your first twelve office visits, which is your responsibility to pay.

OFFICE CO-PAY REIMBURSEMENT REQUEST FORM

Name: _____

Department: _____Date:_____

Office visit dates – First Twelve (Not eligible for reimbursement)			
1.	2.	3.	4.
5.	6.	7.	8.
9.	10.	11.	12.

I understand that I am responsible for the first twelve office co-pays in each year.

Office visit dates - Beyond First Twelve (Eligible for reimbursement)			
13.	14.	15.	16.
17.	18.	19.	20.
21.	22.	23.	24.
25.	26.	27.	28.
29.	30.	31.	32.
33.	34.	35.	36.
37.	38.	39.	40.
41.	42.	43.	44.
45.	46.	47.	48.
49.	50.	51.	52.
53.	54.	55.	56.
57.	58.	59.	60.
61.	62.	63.	64.
65.	66.	67.	68.
69.	70.	71.	72.
73.	74.	75.	76.
77.	78.	79.	80.
81.	82.	83.	84.
85.	86.	87.	88.
89.	90.	91.	92.
93.	94.	95.	96.
97.	98.	99.	100.

I certify that the above are accurate and proof of office visits and dates are attached. Fraudulent claims may lead to immediate termination of employment.

_____

Signature Date